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Vol. CIX AUGUST, 1915 Number 8

NASHVILLE JOURNAL
OF
MEDICINE AND SURGERY

Established 1851

CHARLES S. BRIGGS, A. M., M. D., Editor and Proprietor
E. S. McKEE, M. D., Cincinnati, Associate Editor
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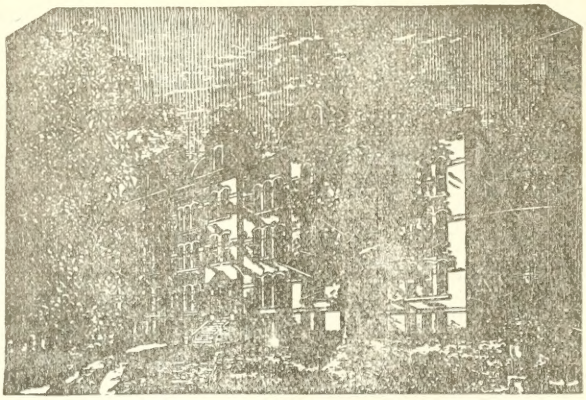

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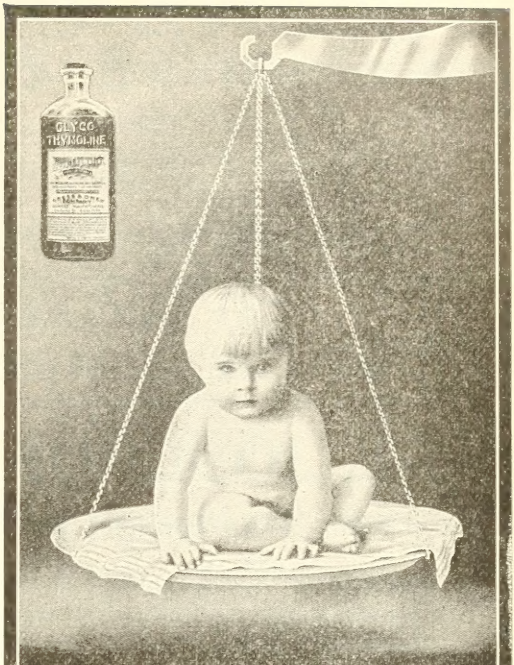

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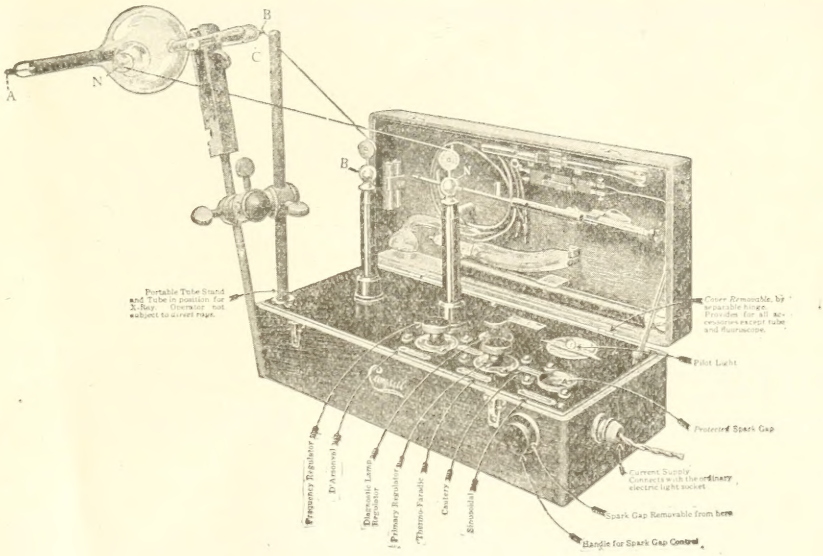

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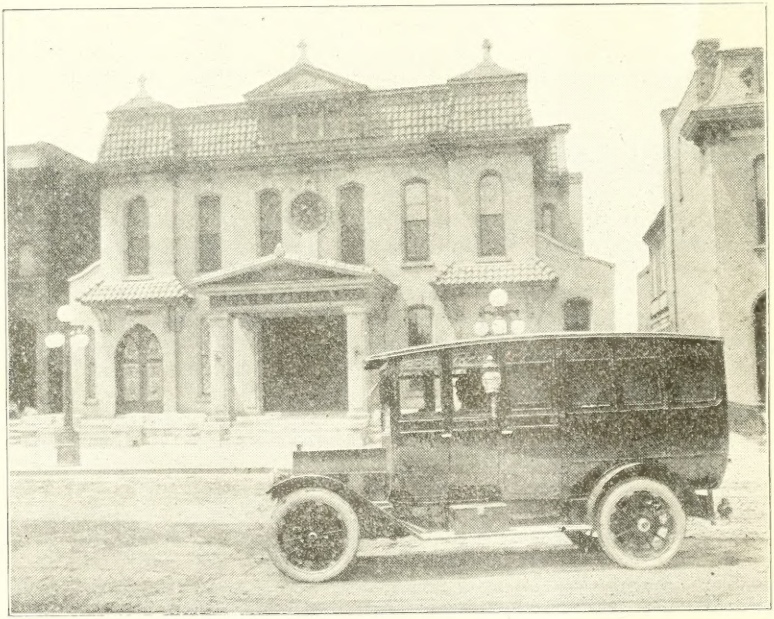

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A.M., M.D., Editor.
W. T. BRIGGS, B.A., M.D., Associate Editor.

VOL. CIX. AUGUST, 1915. No. 8

Original Communications

THE TWENTY-FOURTH ANNUAL REPORT OF SURGICAL OPERATIONS AT THE BRIGGS PRIVATE SURGICAL INFIRMARY.

Reported by
W. T. BRIGGS, M.D., NASHVILLE, TENN.

(Concluded from July number.)

Case No. LII. Vesical Calculus. Mrs. H. H. B., æt. 34, city, was admitted March 14. This patient years ago had suffered severely from pelvic cellulitis and stone in the bladder. A vaginal cystostomy had been performed for removal of stone and the wound left open for drainage in order to relieve the accompanying cystitis. Examination of the bladder showed reformation of stone, so under A. C. E. the urethra was dilated, the soft stone crushed and the fragments removed by irrigation. Relieved of the constant suffering, the patient rapidly regained strength and was dismissed April 16.

Case No. LIV. Cystostomy. Mrs. J. H. M., æt. 38, Alexandria, Tenn. Entered March 15. This patient had suffered severely for several months from vesical tenesmus, the cause of which was not apparent. She was brought to the city for exami-

nation and treatment. An X-ray plate showed several small shadows which were so distributed as to make a tentative, though not very probable, diagnosis of intramural calculi, admissible. The bladder was so tender that instrumental examination without a general anesthetic was impossible. Under A. C. E. anesthesia, a Bransford Lewis cystoscope was introduced and the entire bladder well inspected. There was less evidence of inflammation than expected. The left ureteral opening was dilated and patulous; on the right side there were several openings, each dilated and patulous.

Rest for the bladder being indicated, a vaginal cystostomy was done. The relief from tenesmus was complete and the patient was dismissed with instructions to return later for examination and closure of the artificial fistula.

Case No. LV. Volkmann's Operation for Hydrocele. G. S., æt. 51, Davidson County, Tenn., was admitted March 16, suffering from a typical right sided hydrocele of the tunica vaginalis testis. Under A. C. E. a vertical incision was made in the scrotum and a straw-colored fluid evacuated. The redundant skin was excised and the margin of the tunica was sutured to the skin wound by a continuous catgut suture. The cavity about the testicle was packed with gauze. The swelling following the operation was less than usual and the patient was dismissed April 1.

Case No. LVI. Amputation of the Cervix and Perineorraphy. Mrs. J. H. C., æt. 36, city was admitted March 25. Vaginal examination revealed a considerably enlarged uterus which was heavy and relaxed. There was a bilateral tear in the cervix, and the perineum was markedly relaxed. Under A. C. E. anesthesia the cervix was amputated after the method of Schroeder, the raw surfaces being approximated with chromic catgut. The perineum was repaired after the method of Emmet, removing all cicatricial tissue and closing with catgut, reinforced by three wormgut sutures. The sutures were removed on the eleventh day. The patient went home on April 14.

Case No. LIX. Oöphorectomy and Appendectomy. Mrs. J. A., æt. 28, city, entered March 31, because of severe dysmenorrhea and tenderness in both inguinal regions. Recently she had had several distinct attacks of pain in the appendicular region. Under A. C. E. the abdomen was opened in the middle line and both ovaries, which were found in an advanced condition of cystic degeneration, removed. The appendix, which was inflamed, was also removed, the stump being treated in the usual manner. The parietal wound was closed by seriatim sutures of catgut and through and through sutures of silkworm gut.

Case No. LX. Endometritis. Mrs. H. H. M., æt. 46, Paris, Tenn. Admitted March 31. This patient had been in bad health for several months. She had lost weight and was very nervous. She feared tuberculosis, but a thorough examination of the lungs, combined with the history, enabled us to exclude this disease. Examination of the urine was negative. Vaginal examination showed the uterus enlarged. Under A. C. E. the cervix was dilated and the cavity of the uterus curetted, quite a quantity of granular debris being removed. The gauze packing was removed after 24 hours. The patient responded readily to local treatment with iodine and was very much relieved when she left the hospital on April 24.

Case No. LXII. Ectopic Gestation. Mrs. T. F. M., æt. 24, Paris, Tenn., was admitted April 4 because of a hard nodular tumor of the lower abdomen and menstrual disturbances. According to the history elicited she had suffered from menorrhagia since January, but had not consulted her doctor until the symptoms had lasted for some time. On making a vaginal examination he discovered the tumor and advised operation. In view of the fact that she gave no history of having missed a menstrual period after December, nor severe pain, nausea, vomiting nor fainting, the diagnosis of uterine fibromyoma was made, since on vaginal examination a hard and somewhat nodular tumor with some areas of softening was felt to the side of the pelvis, but apparently attached to the uterus.

Under A. C. E. the abdomen was opened in the midline. The peritoneum was blood stained and the cavity contained both fresh and clotted blood. The uterus was lifted with Museau forceps which tore out of the friable organ, requiring reapplication. The left tube was found distended with blood and ruptured, but there was no active bleeding. After placing ligatures the ovary and tube were removed. Upon removing the clotted blood from the pelvis the right ovary was found buried in adhesions. Since it was useless and the uterus diseased it was decided to do a supravaginal hysterectomy, removing also the right tube and ovary. The cervical stump was covered with peritoneum so that no raw areas were left, and the parietal wound closed by the usual seriatim and relaxation sutures. The patient made a perfect recovery and was dismissed April 28.

Case No. LXIII. Nuchal Carbuncle. J. R., æt. 52, city, entered April 4, suffering from a large carbuncle in the right suboccipital region. The induration was extensive and the pain severe. Under A. C. E. the carbuncle was circumscribed by an incision carried down to the deep fascia and dissected out. The cavity was curetted, touched with carbolic acid followed by alcohol and packed with gauze. The pain was entirely relieved and the cavity soon filled with healthy granulations. Frequent examination of the urine for sugar were made but were always negative.

Case No. IXV. Cervical Adenitis. Mrs. W. B. T., æt. 27, Springfield, Tenn., was admitted April 9. This patient presented a cervical swelling of several months standing on the left side of the neck. Under A. C. E. an incision was made along the posterior border of the sternomastoid muscle and the enlarged glands exposed by retracting the muscle forward. Though the utmost care was taken not to break into the soft glands, the effort was not entirely successful, so it was necessary to pack the cavity with gauze. The wound was partially closed with catgut. The patient was dismissed April 15, but had to return several times for dressings before the wound completely healed.

Case No. LXVI. Carcinoma Uteri. Mrs. J. H. E., æt 58, Paris, Tenn., was admitted April 21. The carcinoma in this case had invaded the vaginal walls, and although the uterus was fairly movable, it was decided a hysterectomy was inadvisable.

Under A. C. E. as much as possible of the mass was removed with scissors and the resulting cavity packed with gauze. After the patient had recovered from the immediate effects of the operation, the wound was treated with gauze saturated with Fowler's solution. There was considerable sloughing of tissue under this treatment, but healthy granulations soon appeared and the patient, much improved in every respect, was dismissed. The family physician was advised to continue the treatment.

Case No. LXVIII. Recurrent Appendicitis.—Appendectomy. J. D. C., æt. 26 years, Hickman County, Tenn., entered April 25 for relief of recurrent appendicitis. The patient had suffered for several years from recurrent attacks at varying intervals—some of the attacks having been very severe. Examination showed tenderness over McBurney's point, also a deep-seated mass. There was more or less pain in the right iliac region all the time. Under A. C. E. the cavity was opened by the customary 4-inch incision in the right linea semilunaris, the appendix released from a band binding it down near its cecal attachment, delivered and removed. The stump was buried by a pursestring suture and the wound in the parietes closed by serial sutures of catgut reinforced by several through and through sutures of silkworm gut. The patient made a satisfactory recovery and was dismissed on the 14th day.

Case No. LXX. Cholelithotomy. Mrs. W. G. B., æt. 38 years, Paris, Tenn., admitted May 3 with a history of very frequent attacks of pain in the right hypochondrium and occasionally slight jaundice following the attacks. Examination elicited marked tenderness over the region of the gall bladder, but no tumor. Under A. C. E., May 4, a vertical six-inch incision was made along the outer border of the right rectus muscle and the cavity opened. The gall bladder was exposed, and after packing well around it with gauze, was opened and a large single calculus located.

This was found firmly fixed and required considerable effort to dislodge it. The stone showed a well marked groove below its middle, corresponding to the beginning of the cystic duct which clasped it tightly at this point. A rubber drain was secured in the gall bladder and a second drain placed alongside the duct. The wound was closed with catgut sutures reinforced with four silkworm gut sutures. Convalescence was uneventful and the patient was dismissed May 30.

Case No. LXII. Fistula in Ano. Mrs. H. W. B., æt. 43 years, Jordonia, Tenn., was admitted May 8. She had suffered for several years from fistula in ano resulting from a peri-rectal abscess. There was an opening on the left side about three-quarters of an inch from the anus. A probe introduced into the opening passed readily into the rectum, showing a complete fistula. Under A. C. E. the fistulous tract was opened into the rectum upon a grooved director, thoroughly curetted and packed with gauze. The wound healed satisfactorily and the patient was dismissed in twelve days with healing nearly complete.

Case No. LXXIV. Recurrent Appendicitis. Mr. J. D. R., æt. 31 years, Hickman County, Tenn., was admitted May 11 with symptoms of recurrent appendicitis. The patient had suffered a number of attacks of severe paroxysmal pain in the right iliac region, from which he would quickly recover after one or two days in bed. At the time of admission he was tender over the appendix and pain was almost constant in that side. Under A. C. E. the abdomen was opened through a four-inch incision in the right linea semilunaris, through which the appendix, enlarged and chronically inflamed was delivered and removed. The stump was buried with a pursestring suture. The wound was closed with serial catgut sutures, five extraperitoneal silkworm gut sutures and skin clips. Recovery was uneventful and the patient was dismissed in fourteen days.

Case No. LXXVI. Rectal Proctitis. H. G . B., æt. 52, Elkhorn, Tenn. Entered May 28. Was referred for treatment because of constant suffering in the rectal region. Examination

disclosed a severe chronic proctitis, but no definite cause for the trouble. Under A. C. E. the sphincter was divulsed, and using a bivalve rectal speculum, two small polypi were exposed and removed. The patient's health was not good and he improved slowly. While in bed it was discovered that he had a pigmented mole on the right side of his abdomen which at times became irritated. The tumor was in diameter as large as a fifty-cent piece, in color, it was almost black. It was removed under local anesthesia by an elliptical incision which passed some distance from the margins of the growth. The patient was dismissed on June 8.

Case LXXIX. Medio-Bilateral Lithotomy. W. E. B., æt. 53, Harriman, Tenn., was admitted May 31. His suffering was supposed to emanate from a cystitis consequent upon an enlarged prostate. Stone, also, had been suspected by several doctors, but was ruled out after search for it under a general anesthetic was negative. His urine showed evidences of a marked cystitis, but digital examination of the prostate gland showed it to be only slightly larger than normal. Examination with Thompson's searcher without an anesthetic detected stone almost immediately upon entering the bladder. An X-ray plate was made, which showed a stone measuring 2¼x1¾ inches, after making allowance for shadows.

Under ether anesthesia, the bladder was irrigated and distended with 8 ounces of boracic solution. With the patient in the lithotomy position, the lithotomy staff was introduced and held in the middle line. With the staff as a guide the urethra was opened in its membranous portion through an incision which commenced just in front of the anus. The cystotome was then introduced, opened and withdrawn, making the bilateral cuts in the prostatic portion of the urethra. The adjustment on the cystotome must have slipped, allowing the blades to reach beyong the limits of the prostate gland, since the hemorrhage was somewhat greater than usual. The finger was then introduced into the bladder and the guide removed. Guided by the finger, forceps were introduced and the stone extracted with some difficulty, since the outer shell of stone peeled off and allowed the stone to fall back into

the bladder. Upon grasping the stone a second time it was removed without any difficulty. The bladder was carefully examined, irrigated throroughly in order to remove all fragments and a large drainage tube introduced. Because of the hemorrhage, gauze was packed around the tube. The tube was removed after 36 hours and the gauze packing dispensed with after the fifth day. Urine passed *per vias naturales* on the twelfth day and the wound ceased draining on the 17th day. The patient was troubled for a short time by involuntary escape of urine when rising from a sitting position. The healing process was slow in this case owing to the size of the wound necessitated by the large stone and the bruising of the tissues during its removal.

The patient's general condition improved in every respect and he was dismissed July 8.

Case No. LXXX. Cholelithotomy and Appendectomy. Mrs. I. H. L., æt. 30, Paris, Tenn., entered May 31, because of constant suffering with right sided abdominal pain and tenderness over the appendix and gall bladder. There had been frequent mild attacks of jaundice. Under A. C. E. a five-inch incision was made at the outer border of the right rectus, the muscle retracted and the gall bladder exposed. After walling off the field of operation the gall bladder was punctured and drained through a canula, the opening enlarged by incision and one hundred and eighty small calculi removed. The ducts were found patulous. A drain was inserted in the gall bladder and fastened by a double pursestring suture and another tube was passed into the hepatoduodenal fossa. Through the same wound the appendix, which was bound down by adhesions and sharply kinked, was removed in the usual manner. It showed signs of inflammation and contained several enteroliths besides a marked stricture at the site of the kink. The parietal wound was closed by the usual seriatim suture of catgut and wormgut except at the point where the drainage tubes emerged. The drainage of bile was quite free but ceased after the twelfth day. The patient was dismissed June 28.

Case No. LXXXII. Urethral Stricture. J. T. W., æt. 54, Gallatin, Tenn., admitted June 8. Urethral stricture following a

severe gonorrhea a number of years before admission. Presence of stricture manifested by a gleety discharge, frequency of micturition and some diminution of the stream of urine. The use of Otis' urethrometer showed two distinct coarctations of the deep urethra just anterior to the bulb. Urethral sound American gauge No. 14 was admitted with difficulty. These strictures were divided with the urethrotome on the roof of the canal and Nos. 18, 19 and 20 conical sounds passed without difficulty. After a week's treatment the patient was dismissed with directions to have sounds passed twice a week for some time.

Case No. LXXXIII. Extreme Varicocele of Left Side. B. W. D., æt. 26, Murfreesboro, Tenn., entered June 12 for treatment of extreme varicocele of the left side of several years standing. The enlargement was unusually great and cause a dragging pain and much mental depression. The patient had worn a suspensory persistently with only slight palliation. Under A. C. E. anesthesia, the veins were exposed by vertical scrotal incision, carefully separated from the vas, number two catgut ligature passed around the veins about an inch apart and the mass of veins excised. The stumps of the mass were then approximated by tying the long ends of the distal and proximal ligatures together and the scrotal wound closed by Michel clips. Rapid healing followed and the patient was dismissed in ten days.

Case No. LXXXV. Lipoma of Back. J. F., æt. 18, Reynolds, Ga., entered June 18. This patient had a small lipoma between the twelfth rib and the crest of the ilium, just to the outer side of the sacrospinalis muscle. It was removed under novocaine anesthesia through a five-inch incision, and the patient was discharged the same day.

Case No. LXXXVII. Appendectomy. M. M. R., æt. 19, Adairville, Ky., entered June 21 with a history of having had several mild attacks of appendicitis. Examination revealed marked tenderness at McBurney's point. Under A. C. E. the appendix was delivered through the usual right rectus incision. The organ was

thickened and contained an enterolith. It was removed in the usual manner and the parietal wound closed by seriatim sutures. Recovery was uneventful and the patient was dismissed July 6.

Case No. LXXXVIII. Fistula in Ano. B. H. G., Henry County, Tenn., entered June 22 suffering from involuntary escape of gas and a slight mucous discharge. On examination there was discovered a small sentinel pile beneath which the opening of a fistulous tract leading into the bowel was discovered with the probe. The tract was laid open on a grooved director. A second tract leading toward the coccyx was also opened and the two wounds converted into one. The wound was packed with gauze and allowed to heal by granulation. The patient was dismissed July 21.

Case No. XC. Appendectomy, Salpingectomy and Oöphorectomy. L. B., æt. 32, city, was admitted June 23. She gave a history of having suffered intermittently with severe paroxysms of pain in the region of the right ovary. The pain was worse during the menstrual period. On examination she was markedly tender. Under A. C. E. the abdomen was opened in the midline and the right tube found distended and fixed by adhesions. The adhesions were so tough that the tube was ruptured during its removal, discharging a thick grayish secretion which was odorless. This discharge was removed by sponging and the tube alone removed, since the ovary seemed perfectly normal. The appendix was also removed. The uterus was suspended to correct its retroflexed position and the parietal wound closed except where the glass tube, inserted for drainage, emerged. The tube was removed after 24 hours and the patient recovered rapidly but was detained at the Infirmary because of the slow healing of the drainage wound. She left for home July 17.

Case No. XCII. Appendectomy. Miss N. L., æt. 21, city, admitted June 30. There was a history of mild attacks of appendicitis, usually associated with her menstrual periods. A. C. E. anesthesia, a median incision was made in order to permit a full

inspection of the uterus and its appendages. These were found in good condition. The appendix was delivered and removed after severing numerous close adhesions. The toilet of the appendical stump was made in the customary manner. The wound was closed by seriatim catgut sutures reinforced by silkworm gut sutures. The appendix was found held in a kinked position by a broad mesenteric like band of peritoneum and showed frequent attacks of inflammation. Recovery was marred only by nausea, which persisted for 36 hours. Dismissed July 15.

Case No. XCIII. Sebaceous Cysts of Scalp. Mrs. S., æt. 44, admitted June 26. This patient presented a number of sebaceous cyst which troubled her a great deal whenever she combed her hair. They were all removed under novacaine anesthesia by linear incisions.

Case No. XCV. Appendectomy. Mrs. M. L. R., æt. 28, Mandyville, Tenn., was admitted July 5 with a history of recurring attacks of appendicitis. Upon examination she was extremely tender over McBurney's point. Under A. C. E. and ether anesthesia the abdomen was opened through the sheath of the right rectus. The appendix was delivered with some difficulty because of a strong band of adhesions which had to be divided before the appendix could be brought into the wound. There was a marked kink in the appendix, distal to which the organ was distended and congested. The appendix was removed and the stump buried in the usual manner. There was experienced some difficulty in closing the wound because of the marked rigidity and the omentum. The patient was quite ill for several days owing to an attack of malaria which, however, promptly subsided under quinine. The patient was dismissed July 27.

Case No. XCVIII. Oöphorectomy. Mrs. J. L. J., æt. 26, Paris, Tenn., admitted July 17. About a year ago this patient had undergone an operation at which the appendix and left ovary were removed. At that time the right ovary showed only slight change and was left with the hope that it might functionate and give no

trouble. Several months ago the patient returned and it was decided best to remove the remaining ovary. Under A. C. E. the abdomen was opened in the midline and the ovary, which had undergone cystic degeneration, together with the tube, removed. The uterus, which was slightly enlarged, was suspended and the parietal wound closed in the usual manner. The recovery was rapid and the patient was dismissed August 3.

Case No. XCVII. Appendectomy. Miss H. L., æt. 20 years, city, admitted July 16 suffering with a severe right-sided abnominal pain, which had begun suddenly 15 hours before. Present marked rigidity of the right rectus muscle and tenderness over McBurney's point. A. C. E. anesthesia July 17. A four-inch incision was made in the right linea semilunaris and the cavity entered through an incision in the posterior layer of the rectal sheath. The appendix was delivered and removed and the stump invaginated with a catgut purse string suture. The ventral wound was closed in the usual manner. The appendix presented a marked constriction an inch from its extremity beyond which were two fecal concretions, the distal one lying in a pocket of pus. The lining of this pocket was gangrenous. The patient made a rapid recovery and was dismissed July 30.

Case No. C—Pelvic Abscess. Mrs. A. W. E., æt. 58, Paris, Tenn., admitted July 22. This patient had been operated for carcinoma uteri by morcellation and the cavity left had been treated by packing with gauze saturated with Fowler's solution until the cavity was filled with healthy granulation tissue. On examination there was no sign of a cavity but there was a recurrent nodule on the right side. This was removed with scissors. While curretting the base a flow of pus appeared. This pus apparently came from the base of the broad ligament. Dilatation of the opening allowed at least a pint of pus to escape. There had been no constitutional symptoms indicative of infection, the patient having returned on account of a slightly offensive vaginal discharge.

The pus cavity was irrigated daily and the patient returned home to have her family physician continue the treatment.

Case No. CIII. Urethral Caruncle. Mrs. A. W. H., æt 60, city, was admitted July 28, because of painful and occasionally bloody urination. Examination revealed a caruncle with quite a long pedicle growing from the posterior wall of the urethra. After using novocaine the urethra was ligated and the growth removed with scissors. On account of an associated cystitis, the bladder was irrigated daily for several days.

ANESTHETIC ANECDOTES.

Related by Dr. E. S. McKee, at the Interstate Association of Anesthetists, at Cincinnati, May 4, 1915.

During the period when a patient is just recovering from an anesthetic, he is bound to have some peculiar sensations, and among these, a few suspicions as to what is still going to happen, predominate. Well, a fellow who had been just operated on, came to, between others, who were on the road to convalescence, and turning to one of them, said: "Well, I'm glad that's over and done with." "I wouldn't be so sure," the patient on his right retorted, "I thought they'd finished with me the first time, but it was a mistake. They'd lost a sponge and had to go back and find it."

Not pleased with this consolation he turned toward the man in the other bed and asked, apprehensively, "What happened to you?" "They forgot a pair of scissors, and as it was the only good pair in the hospital, they insisted on recovering them."

As the patient sank back on his pillow with a groan the door of the private ward was hurriedly opened and the surgeon who had just operated on the last man, asked in a sepulchral voice: "Has anybody here seen my hat, I've lost it?" And the patient promptly swooned.

Occasionally the problem of alcoholism confronts the anesthetist, and at such times he may evince an interest in determining a patient's alcoholic history as a mere matter of curiosity. On one such occasion, after a husky colored roustabout had been returned to bed, after all but clearing out the operating room, the anesthetist asked him some questions, about as follows:

"Sam, do you drink?"

Sam blinked his eyes, uncomprehensively at first, and then whispered hoarsely: "Say, Doc., does a fish swim?"

"How much do you drink, Sam?" pursued the searcher after scientific truth.

Sam's whole attitude expressed a pained surprise as he echoed the anesthetist's question. "How much does I drink? Why, all I kin git—all I kin git, and then some!"

It is related of Sir James Y. Simpson that while administering chloroform to a woman in confinement, the bottle of chloroform was accidently spilled. Nothing daunted by this contretemps, Simpson whipped out a pocket knife, cut out the large piece of carpet, soaked with the spilled chloroform, and calmly continued the obstetrical anesthesia.

Some of those present may think that they have experienced anesthesias of long duration, but back in the pioneer days, when abdominal surgery was being developed, operative procedures were sometimes very protracted. On one occasion that rugged old Cincinnati pioneer, Dr. Thad Reamy, attempted the repair of a vesico-recto-vaginal fistula, following a disastrous labor. The anesthetic was begun at 9 o'clock in the morning, and working in shifts, the anesthesia and operation were continued until 5 o'clock in the afternoon, with a few bites of lunch in between. Remarkable to say, the woman survived, but was not cured. Reamy operated a second time, and had learned so much in his first operation that it only took him one hour and a half. On another occasion he operated across the river on a dusky damsel, the wife of a colored preacher, for a multilocular fibroid. Dr. Robt. Carothers, who delivered the foreword this morning, gave the anesthetic. Dr. Bonefield, President of the Ohio Clinical Surgical Society, assisted. Dr. Gillespie's wife was the nurse, and Dr. Charles Reed, former President of the American Medical Association, held the lamp. This operation began at 3 o'clock in the afternoon and lasted until 9 o'clock that night. During the interval from dusk to the completion of the operation, Dr. Reed was forced to hold an oil lamp with a paper shade, and reflect its light into the abdomen by means of a mirror. Dr. Carothers vividly recalls that on this occasion the woman was under and out of the anesthesia at least thirty times. This scene would really be a remarkable one for an historical painting.

Bill Moon was a noted barber in a country town, who had serious ambitions to become a dentist. He confided his hopes and

aspirations to an uncle, who was one of the wise men of the village, and after due and painstaking deliberation the old man gave Bill this advice: "Bill," he said, "this yer idear of yours to be a dentist appears to me to be a mighty good one. Shucks, you've learned how to HANDLE THE CHAIR IN YOUR BARBER BUSINESS, and putting the folks ter sleep and fillin' or yankin' out their teeth would come as easy to you as rollin' off'n a log."

In these days in which home periodicals discuss everything and the children of the family are taught EUGENICS in the kindergarten, it is not surprising that little Mabel should have been rather precocious for her age. She needed an operation for appendicitis and in order to secure her willing coöperation to undergo the trying ordeal, her mother promised her a new doll. Well, little Mabel, who had just experienced the arrival of a baby brother via the Freiburg Clinic route, withstood the operation successfully, and in order to keep her promise, Mabel's mother laid the beautiful new doll beside her, so that when she awoke from the anesthesia, it would be the first thing she would see. When Mabel awoke to consciousness, she clasped the dolly to her breast, and in triumphant motherliness, said to her parents and the attending nurse, "Just look, I've got a Twilight Sleep Baby, too!"

A rather notorious malingerer, who had occasionally succeeded in mulcting damages out of traction corporations, without being in the least entitled to them, was one day in a real trolley wreck. He was brought to the emergency hospital in an unconscious condition and operated on at once. On recovering from the anesthetic, some time later, he was naturally rather puzzled about his surroundings and he feebly inquired of those around him: "What's happened? Where am I?" The house surgeon, to allay his anxiety, answered encouragingly, "You've been badly injured in a street car accident; but cheer up, you will recover!" "Recover!" repeated the malingerer, suddenly awakening to the full and complete possession of his faculties: "Recover, yes; BUT HOW MUCH!"

Modern methods of "Stealing the Thyroid," were anticipated centuries ago, before any thought had been given to Twilight

Sleep, and gave rise to a cause celebre in France. This occurrence is vouched for by Simpson. The facts in the case revolve around a certain Countess de St. Geran, who, after being in labor for nine hours, was given a potion by the attending midwife and was rendered unconscious until the following morning. When the countess awoke she found that her labor had been in vain, as the existence of any child was denied her. Years afterward it was proven to the satisfaction of the French law courts that the countess had really given birth to a son, during her lethargic condition, but he had been spirited away and brought up as the son of a poor foster-father. After much litigation the boy's claims were fully acknowledged, and he was restored to his mother, and ultimately succeeded to his father's title. But what potion was used to accomplish this early instance of Twilight Sleep has never been disclosed.

The present interest in nitrous oxide anesthesia in surgery, dentistry and obstetrics, recalls the fact that Sir Humphrey Davy was the scientist who originally called attention to its anesthetic qualities. He inhaled the gas to ease the cutting of a wisdom tooth, and whether it was because it was a wisdom tooth, or because Sir Humphry was unusually wise for his generation and day, it is an odd coincidence that he should have then and there suggested its further use in surgical operations.

Few people, locally, are aware of the fact that a medical student named after our own city and a distant relative of our only contribution to the Presidency of the United States, was among those present, when Horace Wells gave his famous demonstration of gas anesthesia at Harvard Medical School. This student was Cincinnatus Taft, and it is a pleasure to record that his version of the incident does not attribute the usual failure to Wells' demonstration, as it is usually written down in the books. In fact, the demonstration was so successful the same night he anesthetized four or five other patients for the students so that they could painlessly pull their teeth.

SOME RESULTS OBTAINED BY THE NEW SERUM TREATMENT OF EPILEPSY.

BY WM. HELD, M.D., CHICAGO, ILL.

In tabulating the following few cases of epilepsy treated with the new serum I have refrained from dwelling upon any theories, realizing that those who are interested in epileptics would rather learn of results obtained than care for theories which are prone to bear earmarks of enthusiasm. To the one fact I desire to call attention, however, namely, that the hemotaxic theory as expressed in all my previous articles on the subject, has since been substantiated by other investigators. I have added the expression of those who are closely associated with the patient whose case is reported, hence are in position to judge from observations of their own as to the progress of their charge.

The serum used in all these cases was produced by the method described by me in former articles, with the one modification, that the patients did not have to furnish the cerebro-spinal fluid, this body fluid having been substituted by laboratory means. Serum and rabific virus, as well as inoculation process, remained unchanged.

Case 1—Female, age 22, epilepsy, grand mal of 16 years duration. Attack lasting ½ to 1 hour, averaging two attacks daily. After attacks, semi-conscious for several hours. Has frequently remained in profound stupor for several days following attack. Cutaneous anesthesia and catalepsy have often been experienced. Tainted history, much impaired mentality, very bad skin eruption.

First serum injection. Same night very light attack, lasting but a few minutes and with no coma following. Marked local irritation on the day following. Patient restless but without the usual dizziness, headache and turning sensation which formerly followed attacks. Pronounced serum rash appears. Light attack again next night with less rigidity and less muscular contractions. Attack lasted about 4 minutes (½ to 1 hour previous to treatment). Patient regains former self promptly with secession of attacks.

Third day. Serum rash disappeared. No attack. Former depression absent. Takes active interest in conversation of other patients. Mother states patient slept well all night, is less forgetful. Patient claims former bad dreams have not bothered her. (Would account for good sleep reported by mother.) An oily secretion is filling the pores of skin. Slight improvement general.

Fourth day. NO ATTACK. Serum injection, much pleased with progress thus far.

Fifth day. NO ATTACK. Serum injection given.

Sixth, seventh, eighth day. NO ATTACKS. This is sixth day without attack.

Ninth day. Serum injection. Reactive attack same night. Former cry, terror and tremor absent. Patient's mother reports attack was more like a nervous chill or like gasping for air than a real epileptic seizure.

Tenth day. Patient up and working around house. Father says "patient is beginning to get her reason back." General marked improvement.

Eleventh to twenty-sixth day. NO ATTACKS. Doing well. No headache or other trouble. Condition shows marked general improvement.

Cose 2—Male, age 12, epilepsy, grand mal, eight years. Series of attacks lasting from one to three days, occurring at intervals of about ten days. Mental impairment. Acne covering entire face since past eight months.

First serum injection. Typical reaction, nausea, local inflamation and attack.

Second serum injection. One attack. Patient did not fall from chair as formerly. The patient's father, a physician, reports "he seems so different, the attacks are a momentary loss of consciousness instead of the grand mal previous to the serum treatment."

Third injection. Still has attacks, much lighter and without the jerking as was formerly the case.

Fourth injection. Father writes: "General improvement, not peevish and mind clearer." During the month following, "Several slight attacks with marked absence of former depressing effect," are reported.

Fifth injection. Father reports: "The boy is now more normal than at any time since his affliction developed. The acne of his face has cleared up, mind is greatly improved. He acts and does the things expected of a normal boy. He is as happy as a meadow lark and we are gaining ground. It seems as if a cloud that hovered over his head had been lifted." The patient's father and doctor signed himself with the prefix "With hope never known before."

Case 3—Male, age 32, grand mal 4 years. Average one attack daily, each lasting from 2 to 6 minutes. During attacks in which patient does not fall he becomes unmanagable, kicks anything or anybody within reach with his feet, drops anything he happens to have in hands, swings arms violently and becomes rigid of entire body at the climax of such attack. Mentality impaired.

After first month's serum treatment the doctor in charge of case reports: Patient decidedly improved in his mental condition. This is so apparent that his sister and brother noticed and remarked about the change.

The patient recalls verses and happenings of past years and passes many days without an attack. He himself states that he feels more like he used to feel before his trouble started. The attacks which the patient now experiences are so light that persons talking to him while he has an attack will not notice the fact. The patient, since this improvement became manifest, has many times been driving and horseback riding for a distance of 16 miles without ever falling from the horse or dropping the lines. He feels more sure of himself, has no convulsions and does not drop anything out of his hands when seized with an attack.

Case 4—Female, aged 20, epilepsy, grand and petit mal of 14 years' duration. Severe attacks every two weeks, dizzy spells very frequent, and unconscious often without convulsions. During menses severe grand mal attacks occur invariably. Grand mal, petit mal, "dizzy spells", unconsciousness and attacks at menstrual periods, constitute a daily disturbance of epileptic nature.

First injection. Local irritation, restlessness, sensation of warmth.

Second injection. Drowsiness following 36 hours later.

Third injection. Drowsy after 36 hours.

Fourth injection. No noticeable reaction.

Fifth and sixth injection. No reaction. The result of serum treatment in this case is summarized in the following report by the physician having charge of the patient: "I certainly am very well pleased so far with the treatment of my patient, as she has been *doing better than at any time since I have known her.* She feels better in every way, especially her dizziness, which she was bothered with a great deal. She also is happier, except for the fact that she just buried her mother within the last week. We all were afraid she might be made worse from shock, but she went through the ordeal splendidly. *She has not had an attack since starting this treatment.* She has gone through one menstrual period and is at the present passing through the second period. She invariably had the attacks at these times before."

Case 5—Female, age 15. Eight years epilepsy, averaging two attacks daily. Bromide in all its forms proved unsatisfactory. When coming for serum treatment has been using two tablespoonfuls of bromide mixture twice daily. Withdrawal of this caused eight attacks, severe type, the same day. During menses, patient required one tablespoonful of the bromide mixture every three hours in order to mitigate attacks which always accompanied this period.

First serum injection. Complete withdrawal of all other medication. Local reaction and *no attacks for* 14 *days.*

Second injection. Local irritation and reactive attack the same day. Patient passed one menstrual period with but one slight attack (and no medication).

Third injection. No attack from date of third. Injection during which time the patient passed another menstrual period without the slightest suggestion of an attack. No attacks for past six weeks. At the writing of this, patient previous to serum treatment has run the medical gauntlet and was completely depending upon bromides without, however, even then obtaining complete secession of attacks.

Case 6—Male, age 39. Epilepsy, grand and petit mal for 19 years. One to six attacks daily. Attack lasts two minutes, followed by confusion. Status epilepticus twice.

First injection. Local irritation and five attacks same day. These attacks were not followed by the usual headache and stupor.

Second injection. One severe and several very light attacks the next five days following the injection.

Third injection. *No attacks of any kind for five days;* then one very light attack on the sixth day, after injection.

Fourth injection. No local irritation, no headache and *no attacks for* 18 *days.*

Fifth injection, without any attacks having occurred since the 4th injection, resulting in two reactive attacks. *No attacks for* 20 *days.* Doctor in charge writes: "Family and friends notice the patient's mental improvement. No attacks, whatever, otherwise."

Case 7—Male, age 16. Grand mal eight years. Very severe convulsions several times daily. Very offensive breath. Patient much worse during last year. Despite bromide and other antispasmotics, daily attacks occur. Knowing that serum injections are often followed by reactive attacks, the doctor in the case feared to discontinue bromide abruptly, hence reduced the dose during serum treatment from day to day until completely withdrawn.

First serum injection. Better pulse than for a long time before. *No attack for one day* after injection, then two attacks the day following.

Second serum injection. One reactive attack following the injection.

Third injection. In the following six weeks the patient, without further treatment and no medication, had but five very light attacks. Physician reports: "The boy is very much better, his mind and skin are clearing up nicely."

Case 8—Male, age 19. Grand mal for 18 months. Several very severe attacks daily. Each attack is followed by profound stupor or sleep last for several hours. At first visit patient is led,

almost carried, by two brothers who support him on either side. Had to be forcibly restrained in attempt to jump out of automobile on way to office. Presents typical picture of epileptic dementia. Does not talk, will not answer questions. Urged into a chair he slights forward, hangs head back and keeps mouth wide open. Rises suddenly, turns around in front of chair and sits down again. Repeats this several times and refuses to give reason for his behavior when asked. This case is reported to be of traumatic origin, patient having been hit on head with sandbag

First injection (dissimilar serum). Next day patient presents same appearance as on the day before. This difference, however, has been noted, that the patient for the first time in 18 months had one spell free day after the injection.

Second injection (dissimilar). *No attacks for five days.* Patient returns for treatment, having come on street car this time and accompanied by only one brother. Patient walks alone, runs unaided and briskly up the few stairs leading to office, smiles and talks and explains that he had been told by his brothers of the two previous visits of which he remembers nothing. The change in patient's mental condition is most decidedly improved.

Third injection (this time autogenous). Patient more alert, helps himself with things for the performance of which formerly assistance was required. During the 15 days following last injection the patient had only four light attacks without in any case experiencing the stupor, sleepiness and sluggishness as was the case previous to the serum treatment.

Case 9—Male, age 23. Epilepsy of severe grand mal for nine years. Attacks are followed by two hours of deep stupor. Attacks, despite bromides, at intervals of about three weeks.

First injection. Severe local reaction, rapidly subsiding under hot applications. Headache, blurred vision and one attack. Usual stupor after attacks, absent. *No attacks for* 10 *days.*

Second injection. Local irritation. *No attacks for 7 weeks.*

Third injection. Slight local irritation. *No attacks for* 11 weeks.

Cases treated by one of the foremost teachers on Diagnosis and Nervous and Mental Diseases in several of the best medical institutions and universities, are summarized in the following letter:

My dear Doctor Held: After years of experience in the treatment of epilepsy in private practice, clinics, hospitals and dispensaries, and after having employed your anti-epileptic serum, I do not hesitate to state that your serum is not only the only logical, but also the only treatment that has so far proven to be entirely harmless and devoid of the detrimental effects of the so-called anti-epileptic remedies. It is, in my opinion, undoubtedly destined to be the long sought for remedy for the sufferers of epilepsy. MAXMILIAN KUZNIK, M.D., LL.B., PH.D.

In all cases cited all bromides and other medication which the patient had been using previous to coming under the serum treatment, were completely and absolutely withdrawn. Case No. 7 and those treated by Dr. Kuznik, are the only exception. But even in these cases the discontinuance, while gradual, was rather abrupt. Carefully scrutinizing all cases that have thus far come under observation the following facts demand recognition, viz.:

Perfect efficiency of the serum to replace bromide. Freedom from any harmful effects and particularly absence of such depressing, tearing down results noticed during bromide medication. Great mental improvement. The latter fact is most encouraging when compared with the amazing large number of epileptics who, during the older forms of treatment ultimately find their way into the insane asylum. The process of preparing the serum used in all the above cases, was the same as formerly described, with the one modification, that the patients did not have to furnish cerebro-spinal fluid, this having been substituted by laboratory means. Serum and rabific virus inoculations remained unchanged.

Extracts from Home and Foreign Journals.

SURGICAL

Ionization Treatment of Septic Wounds.

R. McQueen and L. H. Boothby first clean up and syringe the wounds with sterilized water, or preferably with a 4 per cent solution of sodium salicylate, and if it is necessary to swab the wounds they use sterilized swabs dipped into the solution; after the wound is thoroughly cleaned they plug it firmly and even tightly with sterilized gauze, or ribbon gauze for the small cavities and pockets, soaked in a warm 8 per cent solution of sodium salicylate. Then there is placed over all a gauze pad soaked in the same solution, and over this is placed a piece of lint, folded four times, saturated with the solution, which lint is pinned to a copper mail chain electrode attached to the positive pole of a galvanic battery, and a current of from 5 to 30 milliamperes is passed for at least a quarter of an hour. The chain electrode and pad are removed and a dry piece of gauze is put over the wet dressings with some wool and kept in position by a few turns of a bandage. It is essential to remember the following points in carrying out this treatment: first, no other antiseptic reagent is to be used in the cleaning of the wounds, not even a solution of boric acid, except perhaps peroxide of hydrogen, and even then the wound should be washed out with sterilized water before using the solution of sodium salicylate; secondly, all cavities leading off from the main wound and spaces between broken and splintered bone must be packed with the gauze, and if separate pieces of gauze are used they must all be in contact with the main plug; thirdly, the gauze must be plain, sterilized gauze and must not be prepared with any antiseptic; fourthly, the current should be gradually increased and diminished, and not turned on and off suddenly; and fifthly, the solution of sodium salicylate should be warm.—*Medical Record.*

The Cure of Goiter by the Injection of Boiling Water Into The Substance of the Enlarged Thyroid.

The technique employed in a recent case at the Polyclinic Hospital by John A. Wyeth (*Medical Record,* May 29, 1915), was as follows: The skin and the area to be injected were thoroughly anesthetized by the injection of a free quantity of a one-half of one per cent novocaine solution. A steel syringe, taken out of the boiling cauldron, was filled with boiling water, which was immediately injected by inserting the needle well into the substance of the mass. To prevent scalding the skin, the contiguous surfaces are shielded by a covering of towels, leaving only the point of injection exposed. As the steam or water is apt to escape from the needle, as it approaches the skin, a gauze swab is held as a shield in front of the needle which later is thrust through and into the skin, when the contact is made. From 10 to 20 minims are forced in in one spot. The needle is then partially withdrawn, and the point carried to a new field, and the injection repeated.

Three or four such areas may be injected at one sitting, and these may be repeated as required, in one or two weeks, and so on, until the tumor disappears.

In the case in question, five injections were made in ten weeks, and in three months the goiter had entirely disappeared. The pain was insignificant.—*Medical Review of Reviews.*

Experimental Contribution to the Subject of Cholelithiasis

T. Aryama in Deutsche Zeitschrift fur Chirug. Bd. CXXXII, page 235. The research was undertaken under the supervision of Prof. Payr. Rabbits and, to a less extent, guinea pigs, were utilized. In all of the experiments the cystic duct was tied to produce a biliary stasis, which Naunyn teaches is the fundamental condition for gallstones. In animals normally fed, peculiar formed elements arise after the tying. They are facetted, of variable size, as large as rice, and putty-like. The substance is homogeneous and crystals are sparingly found which are pure cholesterin. If

these animals are injected under the skin with cholesterin, or its oleic ester after ligation, cholesterin granules are produced in the gall bladder. The same results are obtained when cholesterin or the ester are given by mouth, which proves that food may have something to do with the formation of gall-stones. The author remarks that the infrequency of gall-stones in Japan might be explained by the vegetarian diet. Further, no corsets are worn. The author believes that radially formed stones form primarily as such.—*The Lancet-Clinic.*

Experience with Coagulen (Kocher-Fonio.)

Halpern, on the basis of his experience with coagulen as introduced by Kocher and Fonio concludes that it is a valuable means of controlling hemorrhage in carcinoma and after operation. On account of its lack of danger and undesirable after-effects and its prompt action it is of equal value to any hitherto described method of hemostatis and superior to some. It will often succeed in cases in which other means fail.

This substance consists in blood platelets from the blood of animals obtained by fractional centrifugation and mixed with grape-sugar. It is a light-brown, sweet powder, soluble in alcohol, ether, chloroform, salt solution, or water. In using it a 5- to 10-per-cent solution is made fresh in distilled water and boiled two to three minutes to sterilize. The solution is cloudy, but must not be filtered. By spraying a solution of coagulen upon the surface of ulcerated cancers bleeding which did not respond to other measures was controlled. In three cases of cancer of the tongue it proved very effective. In some cases the solution was applied by means of gauze compresses and a bandage. In a case of bladder cancer in which iron, silver nitrate, and adrenalin had been injected without effect, the bleeding was controlled by injection of 100 cc. of 3 per cent coagulen solution. Likewise in military surgery coagulen has been found of good service. The author has had no experience with the subcutaneous or intravenous injection of coagulen.—*The Therapeutic Gazette.*

Internal Aspects of Prostatic Suppuration.

Throughout the entire course of the process until the pus finds escape, Brook says, the chief clinical characteristic of the disease is the prostration which in many if not most instances exactly approximates that of a true typhoid. A very astonishing feature of the disease may be the lack of localizing symptoms. In several cases seen by Brooks no local complaints whatever have been made by the patient and the condition has been discovered only when pus appeared in the urine, when a perineal abscess pointed, or when, as a matter of clinical routine a rectal examination disclosed the origin of the disease picture. The chief points in early differential diagnosis are mostly those of laboratory detail. The Widal reaction is always absent, though, as in most febrile conditions, it may be simulated at times. Blood and urine are negative as to typhoid and paratyphoid bacilli. The final and absolutely diagnostic feature of the syndrome is the examination of the prostate per rectum, and the consequent discovery of an abscess or of a prostatitis. The treatment of the condition is surgical. In cases in which the operation is refused or deemed unwise Brooks suggests the possibility of successful vaccine treatment.—*The Journ. of the Am. Med. Assn.*

Fixation Abscesses.

Cerioli has modified Fochier's original technic for the fixation abscess and advocates its use not only in acute but also in chronic diseases. It might even be given a trial in nervous affections and in syphilis. In acute infectious diseases he has found it of great advantage to supplement it with serotherapy. He injects 1 c.c. of a mixture of 16 parts eucalyptol and 4 parts turpentine, instead of all turpentine. This causes a large abscess to form which shows fluctuation in time but resolution follows and usually without the abscess opening outward. The whole disappears in ten or twelve days. Only in children the abscess generally opens spontaneously. No incision and no dressing are needed, therefore, for adults, as the evacuation of the contents of the abscess is not the

important factor, except in arsenic and lead poisoning, when the abscess is induced to carry off part of the indestructible poison. The purpose of the injection is defeated if the fluid gets into a vein and thus into the general circulation. This happened in one of his cases and transient disturbances and a strong taste of eucalyptol were noticed and no abscess developed. He gives the details of a case of puerperal fever, one of anthrax and one of a deep phlegmon in the neck, all treated by the fixation abscess and serotherapy with favorable outcome. He warns that the cessation of symptoms does not necessarily imply the death of the germs, and hence treatment should not be abandoned too early. In polyneuritis, in facial paralysis, in nodose erythema, and in acute articular rheumatism, he has obtained excellent results with the fixation abscess. In pleurisy it almost invariably renders puncture unnecessary or prevents return of the effusion after thoracocentesis. The work issues from the public hospital at Lonato and concludes with reports of the application of the method in surgical tuberculosis, injecting tuberculin later into the artificial abscess. The results seemed to be favorable. This was still more marked in some cases of sciatica. The modern theories as to vaccination, and especially autogenous vaccines, have much in common with the principle of the fixation abscess, and if the latter can be made a simple and harmless lesion, as in the case with the technic described, it seems to open a prospect of effectual mobilization of the individual defensive forces, under control, as an important aid in the treatment of the most diverse affections. *The Journ. of the American Medical Association.*

MEDICAL

Chronic Hemolytic Jaundice.

Faber reports the details of a case in a girl of 17 whose father and four of the seven other children also present the typical picture of what he calls the Minkowski-Chauffard disease. In all the six members affected, of the family mentioned above, the

spleen was enlarged, resembling in size and consistency the spleen of leukemia. Faber reports further another case, typical in every respect, in a girl of 18. All the other members of her family were healthy, without any signs of jaundice, anemia or splenic enlargement. In this and in his other case the red cells were destroyed in salt solutions that were almost isotonic, 0.64 and 0.7 per cent. The latter figure belongs to the sporadic case. In thirty-three healthy persons or patients with other diseases, hemolysis does not begin with a stronger than a 0.42 or 0.46 per cent solution, and total hemolysis only with a 0.32 to 0.34 per cent. solution. This decreased resistance of the red cells is easily determined by preparing a set of test tubes with salt solution of graduated strengths and adding to each a few drops of the blood of the patient under examination. He appends the case of histories of three patients with the familial type of the disease and treated by splenectomy. The fragility index of the blood was determined before and again three or four years after splenectomy, and also for the other members of the two families. The fragility index was found just as high as the later examinations; in all three hemolysis was evident in the 0.8 per cent salt solution. Although the red cells were thus still abnormally fragile, yet the patients had been restored to clinical health by the splenectomy. The fragility of the blood is the primary factor in the disease and this is the anomaly that is inherited. The red cells were abnormally small in the cases examined for this. The spleen enlarges secondarily, but after its removal the red cells seem to be able to hold their own and hemolysis does not occur so readily. (Compare with recent editorial, July 17, p. 225.)—*The Journal of the Amer. Med. Asso.*

Relation of Calcium to Delayed Coagulation of Blood.

The results of the studies made by Lee and Vincent would tend to show further that while the effect of bile in delaying coagulation is largely counteracted by calcium, yet bile has, in addition, an inhibitory effect on the formation of thrombin and on the action of thrombin already formed. Moreover, bile in very strong

concentration in vitro entirely prevents coagulation even in the presence of an excess of calcium. It is doubted, however, if in obstructive jaundice such concentration of bile ever occurs as will entirely prevent coagulation of blood. Clinically this need of calcium can be met by the administration of any calcium salt. The authors have mainly used calcium lactate in the dosage of 100 grains a day. It must be administered over a period of several days before any marked effect on the coagulation time is seen. The necessity of employing large doses depends on the difficulty of securing the absorption of calcium from the gastro-intestinal tract rather than the need of such large amounts of calcium.—*The Journal of the Amer. Med. Assn.*

The Specific Treatment of Hay Fever.

The *British Medical Journal* of May 29, 1915, tells us that the vaccination method of treating hay fever, initiated by Noon and continued after his death by Freeman, is of so recent introduction that we can not expect independent workers to have much expeperience of it as yet. It is interesting, therefore, to find Sormani, although he has tried it in only a very small number of cases, confirming their statements and encouraging the hopes which their work has aroused. The method, as is well known, consists in injecting subcutaneously gradually increasing quantities of an extract of the pollen of *Phleum pratense;* the initial and subsequent doses are regulated according to the resistance of the patient, which is gauged by the reaction produced by dropping appropriate dilutions of the extract on the conjunctiva. The injections are carried out during the winter months to prepare the patient to resist the action of the pollen in the summer, and the results so far have been very encouraging.

Sormani describes three cases, all of them subject to very violent attacks of the disease, recurring each summer for a period of several years. After a course of injections, one of them passed through a season without any attack whatever, and two with only slight disturbances at long intervals. Of the latter, one was so convinced of his immunity that he gathered some pollen and

snuffed it in order to test his resistance! This gave him a mild attack which lasted a couple of days—an excellent result of so severe a test. Sormani, however, has modified the technique considerably. He uses only freshly prepared extract, finding (unlike Freeman) that it loses greatly in strength on keeping; he prepares it differently, and he does not every time control the dosage by conjunctival installation. The latter he considers unnecessary. The injections being given in winter, that is prophylactically—and not during the season of exposure to the irritant, it is in his opinion sufficient to proceed on the general principles of graduated increase used in other prophylactic inoculations without the elaborate controls desirable in therapeutic inoculation; he gauges his dose by the reaction produced by the previous injections. His extract is prepared as follows: 50 mg. of rye pollen and 50 mg. of the pollen of *Phleum pratense* are ground up together with 1 gramme of sterile sand, and extracted with 4.5 cc. of 10 per cent NaCl solution for two hours. The fluid is poured off and the residue again extracted with 40.5 cc. distilled water for one hour. The two extracts are mixed together, and 5 cc. 2 per cent carbolic added. This gives him his extract, which he reckons to contain 20,000 units in the notation of Noon—*The Therapeutic Gazette.*

A Note on the Use of Liquid Paraffin in Infants.

Hill, in the *Archives of Pediatrics* for February, 1915, reaches these conclusions:

1. In the chronic constipation of infants, liquid paraffin in large doses gives the best results the writer has yet obtained.

2. In severe gastroenteritis and ileocolitis its use was disappointing, possibly because too small doses were given.

3. In conjunction with lactic acid bacilli very remarkable results may be obtained in that group of diseases which are caused by the action of putrefactive or allied positions absorbed from the intestines and finding a favorable, susceptible, sympathetic nervous system—*The Therapeutic Gazette.*

Kisses.

Dr. C. C. Bass of New Orleans who spoke to the Pan-American Medical Congress on Pyorrhea Alveolaris would abolish kisses. The doctor places kisses in the same class as public drinking cups in the dissemination of pyorrhea. Dr. Bass, however, offered the consoling opinion that it takes from thirty to forty years for the destruction of a tooth by pyorrhea.

Dr. E. F. Otis, delegate to the Pan-American Congress from Santo Domingo, said that kissing spreads tuberculosis and suggested the "pat pat" as a substitute. The "pat pat" consists of a smile and pat from each to each on the cheek.

The discussion was also taken up in one of the sections of the American Medical Association. Dr. S. Roy of Washington, D. C., enlisted on the side of the defense of that pleasant diversion. Dr. Roy said in part: "Physicians generally agree that the human mouth harbors many germs, but some are unwilling to migrate. Regarding tuberculosis, I should say that a small fraction of 1 per cent has been brought about through the meeting of the lips. To make the average healthy man and woman timid about showing their affection may have the effect of increasing divorce."—*Pacific Medical Journal.*

Dry Vegetable Cure in Diabetes Mellitus.

M. Labbe, in *Bulletin de l'Academie de Medicine* for January 13, 1914, states that the oatmeal cure does not sufficiently support nitrogenous metabolism. A diet of dry vegetables yielded excellent results in the author's hands. The patient took daily ten ounces (300 grams), of vegetables, five ounces (150 grams) of butter, three to six eggs, and the same number of aleuronate or gluten rolls. A small amount of green vegetables may also be permitted, but no meat. For the ordinary dry vegetables, peas, beans and lentils—soy bean may be substituted.—*Medical Fortnightly.*

Cocoanut Oil in Malaria.

Dr. Kunjan Pillai mentions a curious case which suggests that in certain parts of Ceylon, the ravages of malaria were strikingly rare compared with their malaria-ridden neighborhood. An enquiry resulted in the discovery that the inhabitants of the healthier spots mixed cocoanut oil with their food and bathed with the same oil. Malaria has been responsible for millions of deaths in India from year to year and various measures are adopted for combating the disease and it may be useful to investigate how far our population can be protected from malaria by cocoanut oil—*The West Coast Reformer.*

Another use of cocoanut is recommended by Jackson in the destruction of bedbugs. He states that all that is necessary is to smear a little of the oil over the place where these insects are found, or where there are cracks and crevices, the melted oil may be dropped into them. By the use of this medium any barrack, or hospital ward, or article of furniture or bedding can, in a short time, be freed of the bugs and with a minimum amount of disturbance or upheaval. Cocoanut oil will destroy the ova as well as the adult insect."

We request every one to experiment with this simple and efficacious method.—*Practical Medicine.*

The Modern Dosage of Diphtheria Anti-toxin with Report of a Case of Laryngeal Diphtheria.

On December 1, 1914, I was called in by the family physician to take charge of M. H., aged two years, who was suffering from laryngeal diphtheria. The patient was an only child of intelligent parents in well-to-do circumstances.

The history was as follows: For about ten days the child had had a cold, and for the preceding few days, a cough. The usual home remedies were tried without improvement. On the night before I was called in, the little patient's breathing became difficult and loud. A physician was not sent for until the following

morning, at which time he pronounced it laryngeal diphtheria, and gave 5,000 units of antitoxin.

When I saw the child, the loud, characteristic breathing through an obstructed larynx could be heard in the other rooms; and the substernal, infraclavicular retractions, etc., were most marked. The mother said that the child's breathing had been continuously like this or worse, throughout the night. Temperature between 101° to 102° F. I at once gave 21,000 units more of anti-toxin, making in all 26,000. By evening, the patient was somewhat better, but there was no marked improvement until about eighteen hours. The next morning the labored respirations had disappeared, the child was better in every way, and all immediate danger from the effects of the diphtheria toxin had passed off.

The interesting points in this case are the liability to mistake laryngeal diphtheria for laryngeal croup, the rarity of this condition among the better classes because of the tendency to call upon the physician earlier, and the dosage of anti-toxin. There is no place for conservatism in dosage when applied to a well-marked case of diphtheria of the larynx. A case with similar symptoms at the contagious group of the Cincinnati General Hospital, would probably have received about this amount in a vein, with an additional 15,000 under the skin or intramuscularly. Chances can not be taken where there is an imperfect case history, and, most likely, a poor constitution.

In the above case I feel confident that intubing would have been imperative by night had not an additional dose of anti-toxin been given at once. Recovery was complete without any heart symptoms whatsoever.—*The Lancet-Clinic.*

A Wandering Horsehair.

Guhrauer relates briefly two observations. Three years ago the author's father summoned him and pointed out to him on the sole of the left foot a small inflamed point the size of a pinhead. Beneath it one saw a small, dark splinter. The author, by means of a needle, freed the object, which proved to be a horsehair 20 cm. long. The removal was painless and bloodless. No wound

was left behind. The hair was evidently from a hair mattress. The second case occurred in the author himself. After a bath, as he was putting on his right stocking, he saw above the flexor tendon of the great toe, and projecting for 4 or 5 cm., a horse-hair. This was painlessly removed and measured 20 cm. in length. The wound closed at once. The author has no idea as to how or when the hair entered the foot—*Medical Record.*

OBSTETRICAL

Subcutaneous Symphysiotomy.

Vogt analyzes the experiences at Dresden with this method of facilitating delivery with dystocia, as applied in thirty cases. In seven the pelvis was extremely contracted. The operation was not used for primiparas except in two whose vagina was very wide and there was comparatively little danger of its tearing during delivery. The great advantage of symphyseotomy is that it allows the accoucheur to wait for spontaneous delivery. This occurred in nineteen cases; the others required intervention in the interests of the child. Good labor contractions are indispensable for spontaneous delivery, and intramuscular injection of hypophysis extract may be necessary for this. He makes the injection while the woman is still on the table, and generally waits until the head enters the pelvis and thus all danger of prolapse of the cord is past, before she is taken back to bed. The interval before expulsion ranged from three minutes to four hours and forrty minutes, the longest interval in one primipara with rigid soft parts. There were no signs of injury of bladder or urethra in any instance except that in one case the urine was transiently blood stained. No by-effects nor complications were observed. The button-tipped knife protects against possible injury of the peritoneum, but there may be a hematoma of venous blood and aseptic thrombosis in the veins in the vicinity. Embolism was never encountered but absorption of the hematoma was probably responsible for the febrile course of the puerperium in 44 per

cent of the thirty cases and in 38 per cent of Frank's 140 cases. There was infection in only one of Vogt's thirty cases. The uterus of one woman had already ruptured before the operation was done, and this was not suspected. All the other women made a smooth recovery, and all but three of the children were born in good condition; the symphyseotomy was unable to save these three. There has been much less extravasation of blood and less tendency to thrombosis since a small, curving button-tipped knife has been used to scrape away the ligaments and corpora cavernosa of the clitoris from the edge of the bone. When this is done gently and cautionsly there is no bleeding from the corpora cavernosa.—*The Journal of the Am. Med. Assn.*

Effect of Pubiotomy on Course of Labor.

Williams' article is based on the study of thirty labors, which occurred subsequent to pubiotomy in twenty individuals. Thirteen full-term and three premature children were born spontaneously. In somewhat more than one-third of the cases, particularly in funnel pelves, pubiotomy has resulted in sufficient enlargement of the pelvis to permit subsequent spontaneous labor. Williams' experience has taught him greater conservatism in the employment of pubiotomy which, he says, should not be regarded as an elective operation, except in funnel pelves in young women. In contractions of the superior strait, the idea should be to differentiate the patients into those requiring cesarean section at the onset of labor, and those in whom a spontaneous outcome may reasonably be expected. Pubiotomy should be employed in the latter only when failure of the head to engage after a prolonged second stage has demonstrated that the prognosis was erroneous.

Pubiotomy does not compete with elective cesarean section at the onset of labor, but is far safer than conservative cesarean section late in the second stage. In moderate degrees of contraction of the pelvic inlet, the great field for pubiotomy is in patients who have not been seen until late in labor, or who have been examined by those whose technic is questionable. In such circumstances,

conservative cesarean section is too dangerous, so that the choice lies between pubiotomy, cesarean section followed by removal of the uterus or craniotomy on the living child. If definite infection is present, pubiotomy is contraindicated. In version or breech extraction when there is moderate disproportion, prophylactic laying of the Gigli saw adds greatly to the peace of mind of the operator, as it enables him to resort promptly to pubiotomy if unexpected difficulty is encountered. The most promising field for pubiotomy is in funnel pelves in young women, as it not only permits the delivery of a living child, but offers a reasonable prospect of permanently enlarging the pelvis, so that subsequent labors will end spontaneously. With proper training in the treatment of labor complicated by contracted pelvis, Williams believes that the induction of premature labor can be abandoned definitely.—*The Journal of the Am. Med. Assn.*

Treatment of Inflammation of the Uterine Adnexa.

Amberger, in view of his experience with inflammatory conditions of the uterine adnexa, having reported in all three series of cases, says that in all cases of salpingitis in which the course of the disease is clinically mild, conservative treatment is to be recommended and operation considered only in case palliative treatment does not bring results.

However, in all cases of outspoken salpingitis with severe symptoms, operation should be advised. Hesitancy about operation in the acute stage is not justified. If tubal disease is associated with appendicitis, both the tube and the appendix must be removed at operation. If it is found that peritonitis has been excited by tubal inflammation, operation must be delayed because it is known that the peritoneal involvement will be made worse by operation. Since we find it a great step in advance that conservative treatment of appendicitis is less and less resorted to, it is not easy to see why the treatment of pyosalpinx should contiue in the old-fashioned way. The parallel between the two conditions is marked but not complete. Both threaten life and health

to a great degree and both are curable by a relatively harmless operation. In each disease the organ involved is in most cases of no value to the patient, therefore it is unjustifiable to require the patient to submit to any form of palliative treatment which calls for a large sacrifice of time and money, especially when the organ will in only a very small percentage of cases be restored to normal condition.—*The Therapeutic Gazette.*

Twilight Sleep.

"Twilight Sleep" was not generally favored by the great body of American medical men. Dr. Davis, who has made an exhaustive study of the subject, says that nitrous oxide is far superior to morphin-scopolamin. The safety with which nitrous oxide may be used has long been demonstrated by the dentists. It was the opinion of Dr. Davis that there is as high as 40 per cent of failures with the use of the Freiburg system.

Dr. Charles K. Teter of Cleveland says: "There will be no more blue babies if nitrous oxide is universally adopted." In the "fool proof" apparatus the administration of nitrous oxide is absolutely harmless. The baby is pink, lively and robust. The Twilight Sleep baby is blue, sickly and weak. Like the mother it is affected by the drug for some time."

Dr. Polak, an exponent of morphin-scopolamin, admitted that nitrous oxide was good for the second stage of labor, but maintained that morphin-scopolamin was the best for the first. Dr. Polak says that from 70 to 80 per cent of cases are painless with the Freiburg system. There is an absence of nervous exhaustion in the mother; there are fewer instrument deliveries: more babies born alive and a better secretion of milk after delivery. The doctor confessed that this method has its dangers and limitations.

The National Eclectic Medical Association were opposed to the Twilight Sleep.

Dr. W. N. Mundy brought out the following points:

1. It does not give the surcease from pain which it is said to afford.
2. It leaves a bad effect upon mother and child.
3. It is dangerous to administer.
4. It makes the mother unmanageable.

—*Pacific Medical Journal.*

Editorial

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All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

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Stomach Carcinoma.

We have at hand a reprint of an excellent article * on gastric cancer, by Dr. Jos. C. Bloodgood. In this article he makes the following statement which is based on a careful review of the literature, as well as the experience of those connected with the Surgical Clinic at Johns Hopkins Hospital: "I have gathered from reading the literature that those surgical clinics, in which the total number of cancers of the stomach was larger than the total number of ulcers of the stomach, observed a larger percentage of inoperable cancer and a smaller percentage of cures among the cases in which resection of the stomach was possible, than those clinics in which the number of ulcers of the stomach exceeded that of cancer." At Johns Hopkins from 1890-1905 there were but thirty five cases of cancer of the stomach, of which only 25 per cent were operable. From 1905-1910 there were seventy-six cases, of which only 16 per cent were operable. However, from 1910-1915 of the seventy-three cases of cancer of the stomach 39 per cent were operable. This distinct increase in the number of operable cases of cancer during the period from 1910-1915 was accommied by an increase in the number of ulcer cases referred. This

*Reprinted from the Journal of the American Medical Association, July 19, 1915, pp. 2031-2035.

increase in the number of operable cases Dr. Bloodgood construes as evidence of earlier recognition of cancer. Whether this is true in other clinics or not, it is certainly true that stomach lesions are referred to the surgeon for cure earlier than formally and work on the stomach has lead to a better appreciation of the pathology of that organ and a better technic in operating.

Dr. Bloodgood also calls attention to the fact that duration of the symptoms has no very definite relationship to operability. This, he thinks, rather points to ulcer as often the starting point of cancer, since if cancer always started as cancer the operability would probably decrease as the duration of symptoms increased, allowing, of course, for individual differences in susceptibility.

Internists are recognizing the trouble sooner, but it is also necessary, writes Dr. Bloodgood, to educate the people to realize the significance of certain symptoms and to consult their family physician should such occur. We agree with Dr. Bloodgood in his advice to educate the people, but realize it will be a long time before such education can reach the rank and file of the people. Education has helped in the fight against typhoid and tuberculosis and it will help some in the war against cancer, but we can not hope to educate people in the symptoms of cancers in every organ nor in the symptoms of other diseases just as deadly as cancer. We believe in education too, but different from the "warning symptom" education advocated by Dr. Bloodgood, as well as many other men prominent in the profession. We believe in educating the people to consult their physicians annually, semi-annually or oftener for a thorough examination, not only for cancer but for other insidious, but no less deadly ills; educate the public to feel that physicians are not necessarily pill peddlers, surgeons not always eager to cut; educate the people to expect a thorough examination and good sound advice, rather than a knowing glance at the tongue and a prescription; educate the people, especially in the South, not to expect a complete, thorough examination for a minimum fee. Until the people go to the doctor's office expecting a thorough examination and are perfectly willing to pay for same, we can expect to see

not only carcinomata too far advanced to be operated, but also other diseases too far advanced to cure. How necessary such education is, if we will fight cancer and other diseases the following excerpt shows. (W. T. B.)

Protecting the Human Machine.

We print herewith parts of an excerpt from an address before the Board of Trade of Washington, D. C., delivered by President E. E. Rittenhouse, of the Life Extension Institute:

"Evidence found in the mortality records indicates a marked decline in the power of American workers to withstand the strain of modern life.

In the natural order of this the human machine will wear out and life must end. But why should Americans wear out sooner, now, than they did a few years ago? Why have the chances of early death after reaching the prime of life increased?

How do we know that this has happened? Because of the extraordinary increase in the death rate from the breaking down of the heart, arteries, kidneys, and of the nervous and digestive systems.

These are the diseases of old age. They are reaching down into middle life and below, and increasing there, and apparently at all ages.

These slowly developing afflictions are not only reducing the working, productive period of life but they are lowering the working capacity of the individual often before he realizes it, or recognizes the cause. They are responsible for accidents, for damaged machines, spoiled goods, and other costly errors. They are the concealed enemies of alertness, accuracy and efficiency. Therefore, every employer, small or large, is financially concerned in checking the ravages of this steadily advancing enemy.

An idea of the magnitude of this waste can be gained from the fact that about 410,000 American lives are annually destroyed by these old age diseases, as follows:

Under age 40	60,000
Age 40 to 60	105,000
Above age 60	245,000
	410,000

Virtually all these deaths belong in the group above age 60. The loss of fully eighty per cent of these lives could be postponed from a few days to several years if these diseases were discovered in their incipiency, and the doctor given a chance to treat them in time.

In three decades the records show that the mortality from these diseases has nearly *doubled.*

In the short period of ten years, the census shows that the death rate from these diseases of degeneration increased in a group of over 5,000,000 occupied males as follows:

		INCREASE
	Rate	Per cent
Apoplexy and Nervous system	30.6	19
Heart	38.	29
Kidney and Urinary system	43.	43
Liver and Digestive system	22.5	34

The same story of the declining power of the American people to resist diseases of the vital organs is told by the statistics in the general population wherever comparisons can be had.

The same record shows that the mortality rate has declined from the important communicable diseases, typhoid, tuberculosis, etc., against which an active war has been waged.

Is there any sound reason why employers, and social and religious leaders, who have large bodies of people under their control or influence, should longer ignore this enemy, which is making such a successful raid on American vitality?

Millions of Americans are now afflicted with various diseases in the incipient form. This is to be expected, for all diseases must have a start, and the most of them develop slowly. It is during this period, when sickness is approaching without the victim's

knowledge, that periodic physical examinations perform their greatest service.

The Life Extension Institute has given thorough physical examinations to a large number of officials, clerks, and other employes of banks and commercial houses—the average age being thirty years.

This experience is of especial interest because these people would naturally be looked upon as a preferred class, so far as health hazard is concerned. They were an orderly, temperate and well-nourished group.

It must be remembered that these examinations were made of apparently well people who were on their feet and at work. The purpose was not merely to find disease, but to report the physical condition of each individual, which includes physical defects and tendencies that lead to disease, as well as actual health impairments ranging from the incipient to the serious forms.

3% passed as normal.

38% were found with minor impairments or tendencies indicating the possible early approach of disease, which, with proper attention, could be headed off, and these people were advised accordingly.

51% had from moderate to serious impairments needing medical treatment or supervision.

8% were seriously impaired, needing immediate medical attention. The entire 59% were sent to their doctors for treatment or guidance.

Now here are two significant facts relating to these people. Virtually all of the 59 impaired cases in each one hundred were either curable or serious results postponable—the most of them for many years. Over 90 per cent of this class did not know of their danger.

Naturally, those in the minor class are steadily dropping into the moderate class, and those from the moderate class are passing into the serious class, and from the serious class to invalidism and —the end. Now the question: Why should we in this age permit ourselves and our employes to continue this habit of drifting blindly into fatal illness?

Is it not perfectly obvious that by giving these people periodic health examinations and hygienic advice and guidance in the habits of life, the annual sick and death list in this group will be reduced?"

The above address speaks for itself, and very eloquently, too. It emphasizes the necessity of regular, careful medical examinations if the span of life will be increased. It shows that eternal vigilance is the price of health as well as liberty. Furthermore, if cancer is increasing, as many affirm, then is not this increase in the diseases of old age a partial explanation of the increase in cancer? Until some more definite cause of cancer is found would it not be wisdom to fight cancer indirectly by fighting old age, since age is the most important predisposing cause? Cancer occurs in the young, but so seldom that we all associate cancer with middle life or old age. In spite of the fact that cancer is now considered a strictly local disease in its incipiency, and for that reason curable if quickly removed, it is nevertheless true that age predisposes in some inexplicable manner. Just how, no one knows, but that it does, no one can deny. (W. T. B.)

Publisher's Department

Nervousness.

As to the drugs to be given in nervousness, there is only one class which has a specific influence in controlling nervous excitability. This is the bromides, and it has been found that a mixture of several of them is better than one alone. For this reason many physicians prefer Peacock's Bromides, which is a splendidly balanced mixture and which even on prolonged use gives rise to little or no gastric disturbance. The dose must be regulated according to the state of the patient, but when judiciously given there is never any difficulty of controlling even the more severe cases of nervousness. In the more severe forms of neurasthenia, complete rest in bed with small doses of Peacock's Bromides is usually more effective than any other treatment. In epilepsy, which is also a disease in which the brain reactions are exaggerated, larger doses are needed, but as this preparation is more pronounced in effect than other bromides the enormous quantities which are sometimes prescribed are never necessary in order to control the convulsions, and as the digestion is rarely if ever deranged it can be given for a much longer period of time.

Intestinal Toxemia.

The investigations of Metchnikoff and Schmidt, together with the later studies of Lane, Jordan and many others have lain such emphasis on the evils resulting from intestinal stasis that it is at last recognized that no small proportion of the diseases afflicting the human family are directly attributable to faulty elimination of the intestinal accumulations in the lower bowel. For a long time, to be sure, the evils of chronic constipation have been realized, but it is doubtful if, until Lane began to speak of the large intestine as the "cesspool of the human body," the dangers of intestinal putrefaction were fully appreciated.

It is hardly probable that Lane's radical treatment of "short circuting" the bowel—the removal of three to eight feet of intestine—will ever be popular and simpler measures will unquestionably hold a definite place in the management of intestinal stasis for some time to come.

Many and various are the remedies that have been employed with more or less success, but among recent remedies brought forward for accomplishing intestinal elimination, and, what is often of even greater importance, the removal of certain local intestinal conditions contributory to, or the result of the bowel stasis, Prunoids unquestionably stands first. This unique combination of phenolphthalein and other carefully selected drugs has been found an evacuant of exceptional value. Its effect is prompt and certain, with none of the iniquities of the commonly used laxatives and cathartics. Prunoids do not gripe nor occasion the slightest discomfort, although they produce very copious movements. Most important of all, however, is the physiologic effect on the intestinal glands and muscular tissue that follows their systematic use. Unlike most cathartics, the reactionary effect never tends to increase the constipation. One effective dose is often followed by regular movements for several successive days, and used routinely, in the absence of organic causes, gradual diminution and at last complete cessation of the remedy is always possible; in other words, a more or less permanent correction of the constipation is an almost invariable result.

Such a preparation, with its broad field of satisfactory application, can not fail to appeal to the zealous physician. Any medical man who is not familiar with the exceptional clinical value of Prunoids, is urged to write for samples to the Sultan Drug Company, Saint Louis, Mo.

Notwithstanding the large number of Hypophosphites on the market, it is quite difficult to obtain a uniform and reliable Syrup. "Robinson's" is a highly elegant preparation, and possesses an advantage over some others, in that it holds the various salts, including iron, quinine and strychnine, etc., in perfect solution, and is not liable to the formation of fungus growths. (See adv. in this issue.)

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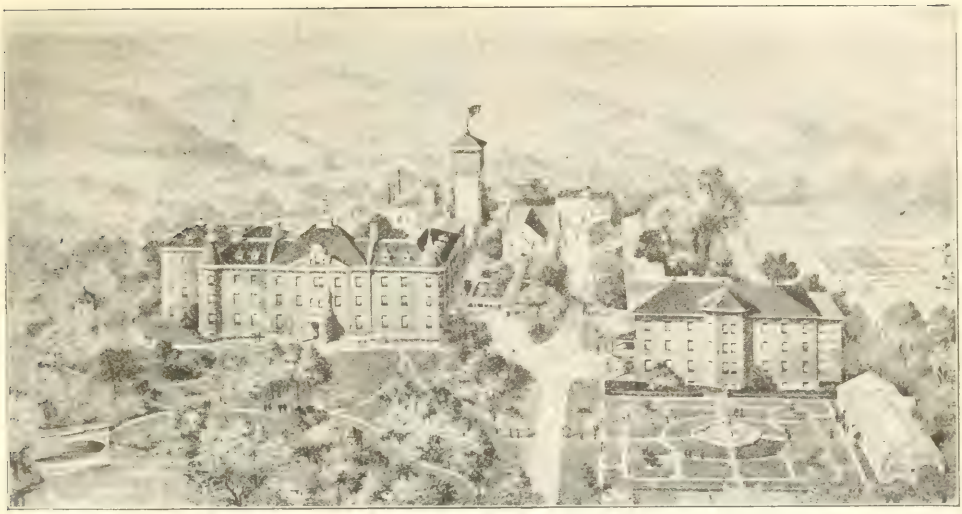

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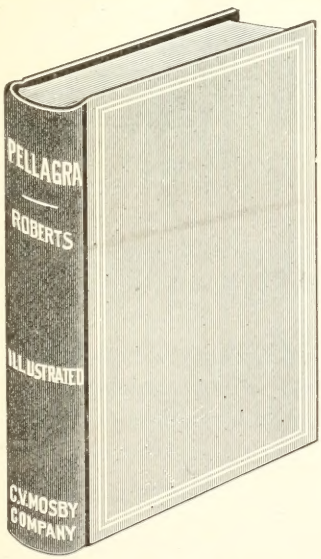

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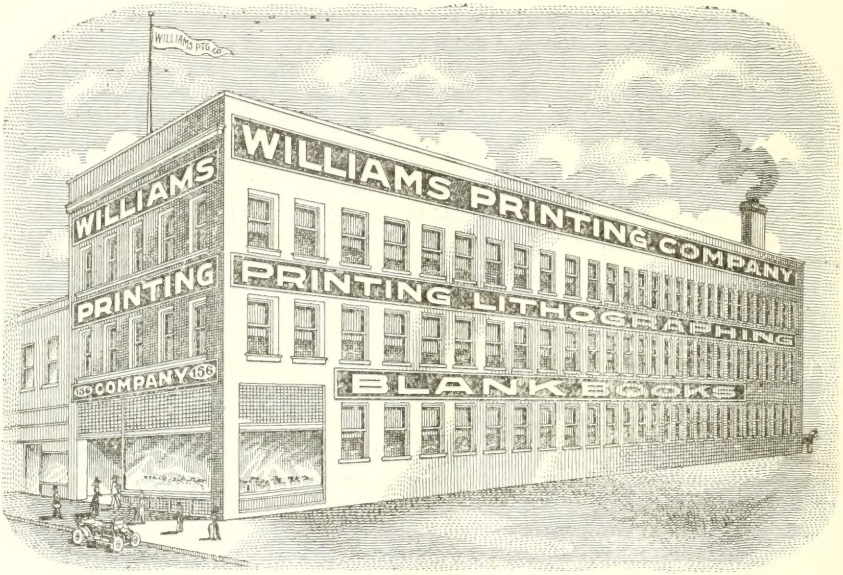

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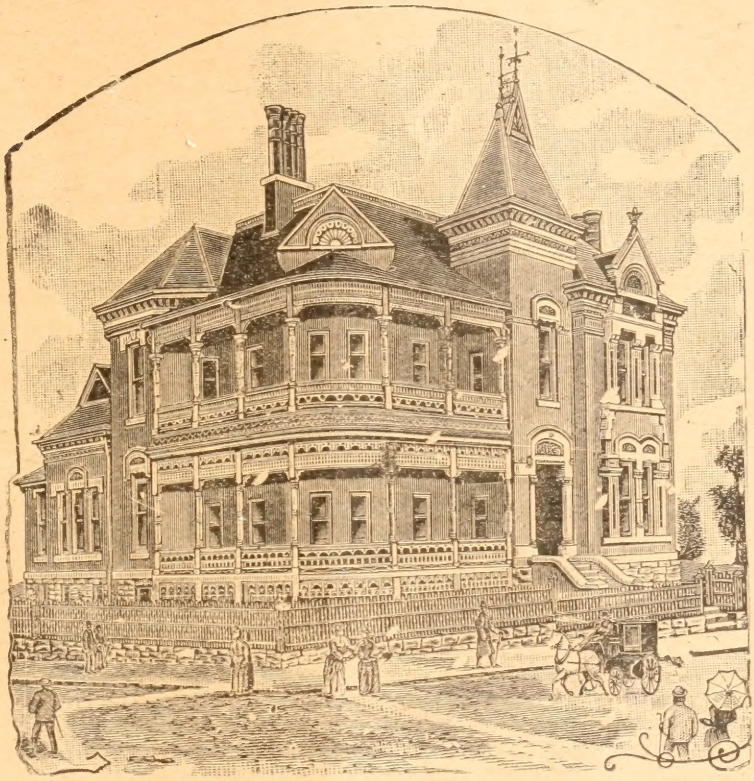

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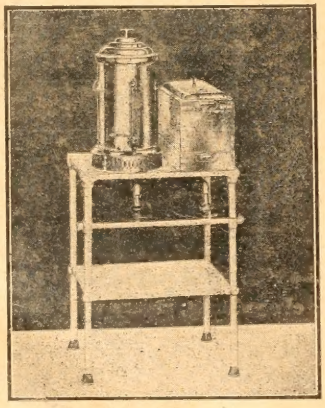

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